STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155059	A. BUILDING 01 B. WING	06/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1500 GRANT STREET HUNTINGTON, IN46750

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/21/11 Facility Number: 000020 Provider Number: 155059 AIM Number: 100288690 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies This one story facility was determined to be of Type II (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 85 and had a census of	K0000	Please accept the following Plan of Correction as our Credible Allegation of Compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	61 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/24/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 4 of 4 storage rooms with combustible storage, measuring over 50 square feet in size, were provided with a self closing device. This deficient practice could affect any residents evacuated through the receiving area and ten residents on the west hall. Findings include:	K0029	K0029 No residents were affected, but the deficient practice has the potential to affect all residents. Automatic self-closers were purchased and installed on the entry doors for all (4) rooms outlined in bullets a, b and c in the findings for this deficiency. These self-closers were installed on or before 7/7/11. All self-closers have been tested and doors close completely and latch properly. Maintenance staff will test the doors to ensure the self-closers operate properly on a weekly basis for (4) weeks to ensure the closers continue to work	07/07/2011

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	Based on observation with the Maintenance Supervisor and Maintenance Technician # 1 on 06/21/11 from 11:45 a.m. to 1:20 p.m., the corridor door to the following rooms with combustible storage, measuring over 50 square feet in size, lacked a self closing device: a) the west hall medical supply room with cardboard boxes of "briefs," b) medical storage in the receiving area containing cardboard boxes and boxes of alcohol based hand sanitizer and rubbing alcohol, c) two corporate storage rooms full of cardboard boxes of files in the "closed hall" beyond the corporate meeting room. This was confirmed by the Maintenance Supervisor at the time of observations. 3.1-19(b)		properly. All systematic changes to correct the concerns outlined in the findings for this deficiency have been remedied. DOC 7/7/11	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and	K0038	K0038 No residents were affected, but the deficient practice	07/08/2011

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	interview, the facility failed to ensure 1 of 11 exit discharge paths were readily accessible at all times. This deficient practice could affect residents evacuated through the south hall exit in the event of an emergency. Findings include: Based on observation with the Maintenance Supervisor on 06/21/11 at 1:40 p.m., the south hall exit door required excessive force to get the door opened after the magnetic lock was released. Based on an interview with the Maintenance Supervisor at the time of observation, he said there is a problem with the door jamb and they have worked on it several times. 3.1-19(b) 2. Based on observation and interview, the facility failed to provide an exit discharge that was readily accessible for 1 of 11 means of egress to a public way. LSC Section 19.2, Means of Egress Requirements, requires every exit discharge, exit location and access		has the potential to affect all residents. The following work was completed to remedy the findings in items #1 and #2. #1 - On 7/8/11, the South Hall exit door was modified such that the top of the door no longer catches on the top of the door jam. Also, the hinges were re-hung. This door now swings open and closed without excessive force after the magnetic lock is released. #2. - On 6/23/11, the 24" x 12" section of sidewalk mentioned in the finding was patched with new asphalt to cover roughly 48" x 24" of sidewalk. An additional area on the same sidewalk was repaired with roughly 36" x 16" of asphalt. The new asphalt adhered properly and the deteriorated areas have been covered. All systematic changes to correct the concerns outlined in the findings for this deficiency have been remedied. DOC 7/8/11	

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	shall be in accordance with LSC Chapter 7. LSC 7.1.6.3 requires the means of egress be nominally level. This deficient practice affects all residents evacuated through the service hall exit in the event of an emergency. Findings include: Based on observation with Maintenance Technician # 1 on 06/21/11 at 11:10 a.m., a twenty four by twelve inch section of the asphalt sidewalk at the service hall exit is deteriorating and breaking apart with missing pieces from the sidewalk. This is creating a trip hazard. This was acknowledged by the Maintenance Technician # 1 at the time of observation. 3.1-19(b)			

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K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 2 of 4 sprinklers heads in the Director of Nursing's (DON) office, 2 of 4 in the north lounge and 2 of 4 in the north dining room were separated by at least six feet as required by NFPA 13. NFPA 13, Section 5-6.3.4 requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect residents in or near the DON's office and any of the seven residents in the north hall. Findings include: Based on an observation with the Maintenance Supervisor and Maintenance Technician # 1 on 06/21/11 from 12:05 p.m. to	K0056	K0056 No residents were affected, but the deficient practice has the potential to affect all residents. On 7/8/11, the following was completed to remedy these findings. a. DON's Office - One (1) sprinkler head (noted as above sink) was capped off. Three (3) existing sprinkler heads remain and provide appropriate coverage for this room. b. North Lounge - One (1) sprinkler head was relocated by approximately 2' to allow for no less than six feet between sprinkler heads in this area. c. North Dining Room – One (1) sprinkler head was relocated by approximately 2' to allow for no less than six feet between sprinkler heads in this area. One (1) sprinkler head was relocated to from approximately 2.5 inches from the wall to approximately 7 inches from the wall. Our sprinkler system was tested by the vendor and working properly at completion of the moves. Our sprinkler system is	07/08/2011

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	12:35 p.m., sprinkler heads were located less than six feet apart in the following locations: a) in the DON's office the sprinkler heads above the sink were fifty five inches apart, b) in the north lounge the sprinkler heads in the center of the room were fifty nine and one half inches apart, c) in the north dining room the sprinkler heads in the center of the room were fifty nine and one half inches apart. Measurements were provided by the Maintenance Supervisor at the time of observations. 3.1-19(b) Based on observation and interview, the facility failed to ensure 1 of 4 sprinkler heads installed in the north lounge was at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from the wall. This deficient practice could affect any of the seven residents in the north hall. Findings include:		tested quarterly to ensure it is working safely and properly. All systematic changes to correct the concerns outlined in the findings for this deficiency have been remedied. DOC 7/8/11	

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	Based on observation with the Maintenance Supervisor and Maintenance Technician # 1 on 06/21/11 at 12:27 p.m., the sprinkler head near the east wall of the north lounge was mounted two and one half inches from the wall. Measurements were provided by the Maintenance Supervisor at the time of observation. 3.1-19(b)			
K0067 SS=E	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 1 of 6 zones did not use the adjoining egress corridors as a portion of the return air plenum for heating, ventilating and air conditioning (HVAC) ductwork serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning	K0067	K0067 No residents were affected and we feel that this deficiency is not putting any residents at risk. We will request a Life Safety Waiver for this deficiency. There are rooms using the egress corridors as a return air system. On 6/30/11, the facility modified the HVAC system such that it is tied into the fire alarm system. This will reduce the spread of smoke or fire	07/21/2011

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	and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return or exhaust air system serving adjoining areas. This deficient practice could affect residents, staff and visitors in zone 6. Finding include: Based on observation and interview with the Maintenance Supervisor and Maintenance Technician # 1 on 06/21/11 at 11:40 p.m., all 24 resident rooms in Zone 6 were using the egress corridors as a return air system. An interview with Maintenance Technician # 1 confirmed return air was exhausted into the corridor for all resident rooms on Zone 6. The facility has modified the HVAC system so activation of the fire alarm system shuts off supply air fans. Additionally, duct work connected to the supply air fans was equipped with duct detectors located downstream of the air filters. Finally, since the HVAC ducts penetrated the smoke barrier walls, smoke dampers which close upon activation of the		through the HVAC system. Ductwork is connected to the supply air fans which are equipped with duct detectors located downstream of the air filters. When these are activated the duct detectors shut off the supply air fans. Smoke dampers are installed at the walls, since the HVAC ducts penetrate the smoke barrier walls. The facility is respectfully requesting a waiver of the K0067 standard on 7/8/2011 (Attachment A) and anticipates gaining compliance through this waiver. DOC 7/8/11 pending approval of Life Safety Waiver	

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	fire alarm system have been installed at the smoke barrier walls. 3-1.19(b)			
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage areas were separated by construction with a one hour fire resistant rating. NFPA 99, 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.2. NFPA 99, 4-3.1.1.2(a)requires at least one hour fire resistant enclosures shall be provided for the storage of oxidizing agents such as oxygen. This deficient practice could affect any of the twenty three residents on the center hall.	K0076	K0076 It is the policy of Miller's Merry Manor Huntington that stationary liquid oxygen units will be stored in approved storage rooms that meet Life Safety Code regulations. No residents were affected, but the deficient practice has the potential to affect all residents. The stationary liquid oxygen unit was moved from the hallway to our oxygen storage room just after 1:55pm. The nurse who was responsible for the temporary staging of the unit was in-serviced on 6/21/11 (Attachment B) as to the proper storage of liquid oxygen units. All nursing staff will be in-serviced on the proper storage and transfer of oxygen units on or before 7/21/11. DON, Nursing Managers	07/21/2011

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	Findings include: Based on an observation with the Maintenance Supervisor, Maintenance Technician # 1 and the Administrator on 06/21/11 at 1:35 p.m., a stationary liquid oxygen unit was observed in the corridor across from the DON's office. At 1:55 p.m. on 06/21/11, the stationary liquid oxygen unit was still stored in the corridor. Based on interview with the Administrator at the time of this observation, he could not explain why the liquid oxygen unit was stored in the corridor. At this time the Administrator interviewed a unit nurse and was told the stationary liquid oxygen unit was empty and she was busy and hadn't had a chance to take it to the oxygen storage room. 3.1-19(b)		and Administrator will monitor proper storage. DOC 7/21/11	
K0144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to provide emergency task lighting in and around	K0144	K0144 No residents were affected, but the deficient practice has the potential to affect all residents. On 7/8/11, two	07/08/2011

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	1 of 1 generator sets in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested, and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110 Section 5-3.1 requires the EPS (Emergency Power Supply) equipment location shall be provided with battery powered emergency lighting. This deficient practice could affect all occupants. Findings include: Based on an observation with Maintenance Technician # 1 on 06/21/11 at 11:12 a.m., the only battery powered light at the emergency generator was a small panel light used to light the generator panel only. This was acknowledged by Maintenance Technician #1 at the time of observation. 3.1-19(b)		mini-LED lights were installed inside the shell of the generator. Each is permanently affixed and has the ability to swivel to adjust lighting on the main panel and around panel. These lights will be inspected during monthly preventative maintenance inspections and/or during monthly generator tests. All systematic changes to correct the concerns outlined in the findings for this deficiency have been remedied. DOC 7/8/11	